1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2509 Item 13 filed 8397 2/5/68

Reg. Dist. No. 02491

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 28 HRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: RT.#4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY, Middle L., Last AARON

4. DATE OF DEATH: Month MARCH, Day 19, Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: AUG. 27, 1890

9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): PENNA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~BENJAMIN~~ Joseph H. WELLER

14. MOTHER'S MAIDEN NAME: LAURA WERTZ

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-7175

17. INFORMANT: MEMORIALHOSPITAL. Address: CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

	Cause	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Myocardial Infarction, Post-Lateral	2 days
DUE TO (b)	Arteriosclerotic & Hypertensive Cardio-vascular Disease	? ?
DUE TO (c)	Diabetes mellitus	10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 — Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 Jan., 1950, to 19 Mar., 1959, that I last saw the deceased alive on 19 Mar., 1959, and that death occurred at 12:40P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Alfred Van Ormer M.D.
ADDRESS (Street, city or town, state): 122 S. Centre St. Cumberland, Md.
DATE SIGNED: 21 Mar. 59
PHYSICIAN'S NAME (Type): W. A.VAN ORMER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/22/59

22c. NAME OF CEMETERY OR CREMATORY: RoseHill Cemetery

22d. LOCATION (City, town, or county): Cumberland (State): Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ruth E. Silcox. ADDRESS: Cumberland Maryland

24a. REC'D BY REGISTRAR DATE: MAR 23 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M I 60 0 1

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02495

Reg. Dist. No. 2501

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 37 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 719 MARYLAND AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First VIRGINIA Middle Clara Last AFRICA

4. DATE OF DEATH: Month MARCH Day 14 Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JANUARY 6, 1906

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND, Cumberland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE S. EASTON

14. MOTHER'S MAIDEN NAME: LULA A. EVERSOLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: WARWICK & MEMORIAL AVENUE (Address) MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Metastatic — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Carcinoma, Colon spreading to bones — 5 years
DUE TO (c): and Lungs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

153.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1954, to 14 Mar, 1959, that I last saw the deceased alive on 14 Mar, 1959, and that death occurred at 2:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Carlton Brinsfield M.D.
ADDRESS (Street, city or town, state): 232 Baltimore Ave. Cumberland Md.
DATE SIGNED: 3-17-59
PHYSICIAN'S NAME (Type): DR. CARLTON BRINSFIELD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/17/59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kuns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02496
Reg. Dist. No.

2570

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 3yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg
d. STREET ADDRESS: 65 E. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nelson — Middle: Junior — Last: Albright

4. DATE OF DEATH: Month: Mar — Day: 29 — Year: 1959

5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-2-1934

9. AGE (In years last birthday): 25 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: P & K Garage
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nelson Wm. Albright
14. MOTHER'S MAIDEN NAME: Leona Fazenbaker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: 220-28-9967
17. INFORMANT: Mr. Robert Garlock Rt.#2 Zihlman, Address Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Rt Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 Hrs.
DUE TO (b): Rupture of Congenital Aneurism of Rt Meningeal Artery
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

7547

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF M.D.: W O McFarland — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: Mar 30 1959

EXAMINER'S NAME (Type): W O McFarland M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-1-59
22c. NAME OF CEMETERY OR CREMATORY: Fort Ashby Cemetery
22d. LOCATION (City, town, or county) (State): Fort Ashby W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph H. Whitesell — ADDRESS: Hafer Funeral Home 23 E. Main, Frostburg, Md.
24a. REC'D BY REGISTRAR — DATE: APR 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02497

2505

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

c. LENGTH OF STAY IN 1b: 10/13/1944

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mt. Savage

d. STREET ADDRESS: New Row

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Susan — Middle: — Last: Albright

4. DATE OF DEATH: Month: March — Day: 6, — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/20/1880

9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Laundry Worker, Laundry

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Levi Albright

14. MOTHER'S MAIDEN NAME: Sophia Koontz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: P.O.Box 599 — Address: Cumberland, Md.
Allegany County Infirmary Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: ?

4222

DUE TO
(b): Cerebral arteriosclerosis — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO
(c): Arthritis Deformans — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile deterioration

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/1/52, 19__ to 3/6/59, 19__, that I last saw the deceased alive on 3/5/59, 19__, and that death occurred at 1:55P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean M.D. — ADDRESS (Street, city or town, state): 49 Green St. — DATE SIGNED: 3/6/59

PHYSICIAN'S NAME (Type): Dr. James E. McLean — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 9, 1959

22c. NAME OF CEMETERY OR CREMATORY: Methodist Cem.

22d. LOCATION (City, town, or county) (State): Mt. Savage, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Charles L. George, Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: MAR 9 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02498

2506

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1003 Harding Ave.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND,
d. STREET ADDRESS: 1003 Harding Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY — Middle WILLIAM — Last ALDERTON

4. DATE OF DEATH: Month March — Day 5, — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 26, 1907

9. AGE (In years last birthday): 51 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine operator

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Davis, W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry E. Alderton

14. MOTHER'S MAIDEN NAME: Ellen Edwards

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-07-4982

17. INFORMANT: Mrs. Helen A. Alderton — Address: Cumberland, Md. 1003 Harding Ave.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary Artery Disease

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-16, 19 58 to 3-5, 19 59, that I last saw the deceased alive on _____, 19_____, and that death occurred at 3:45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. J. Williams M.D. — ADDRESS (Street, city or town, state): 122 So. Centre St., — DATE SIGNED

PHYSICIAN'S NAME (Type): W. F. Williams M.D. — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/8/59

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Charles L. George Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: MAR 9 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Howe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02499 Reg. Dist. No. 2507

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME BM 2/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Constitution Park

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 242 N. Mechanic St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle C. Last AMAN
4. DATE OF DEATH: Month March Day 10, Year 19 59
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: April 21, 1910
9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Meat Cutter
10b. KIND OF BUSINESS OR INDUSTRY: A. & P. Market
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Geprge W. Aman, Sr.
14. MOTHER'S MAIDEN NAME: Emma Mackart
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214 05 5744
17. INFORMANT Address: Mrs. Emma Aman, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b): Coronary Sclerosis — - - -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: March 10, 1959
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/13/1959
22c. NAME OF CEMETERY OR CREMATORY: St. Peter & Pauls Cem.
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight
ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: MAR 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2508 **CERTIFICATE OF DEATH**

03757
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 6 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: PENNSYLVANIA
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEDFORD 75x-3
d. STREET ADDRESS: RT. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: BABY Middle: BOY Last: ARNOLD

4. DATE OF DEATH: Month: MARCH Day: 23 Year: 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 23, 1959

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months: Days: 8 Hours: Min.: — IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES D. ARNOLD

14. MOTHER'S MAIDEN NAME: MARILOU ARNOLD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity - 32-33 wks.
DUE TO
(b): Atelectasis
DUE TO
(c): Partial separation of P. Lacenta

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

761.5

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 23, 19 59, to Mar 23, 19 59, that I last saw the deceased alive on Mar 23, 19 59, and that death occurred at 10:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: W R Hodges M.D.

ADDRESS (Street, city or town, state): Cumberland, Md

DATE SIGNED: 3/25/59

PHYSICIAN'S NAME (Type): DR. W.ROYCE HODGES

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/24/59

22c. NAME OF CEMETERY OR CREMATORY: Bedford Cemetery

22d. LOCATION (City, town, or county) (State): Bedford Pa

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Deuel

ADDRESS: Bedford, Pa

24a. REC'D BY REGISTRAR DATE: MAY 1 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Howe

2060313XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02500

CERTIFICATE OF DEATH

2586 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellerslie
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellerslie
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles Middle L. Lost Beal

4. DATE OF DEATH: Month March Day 3, Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 13, 1877

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railraod employee

10b. KIND OF BUSINESS OR INDUSTRY: Penna. Railroad

11. BIRTHPLACE (State or foreign country): Palo Alto, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Beal

14. MOTHER'S MAIDEN NAME: Nancy Bennett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Violet Cooper. Address: Ellerslie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Heart Disease — 4-6 yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Uremic convulsive Failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 19 57 to March, 19 59, that I last saw the deceased alive on March 1, 19 59, and that death occurred at 3:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William R. James M.D. ADDRESS (Street, city or town, state): 44 N. Centre St. DATE SIGNED: 3-5-59

PHYSICIAN'S NAME (Type): William R James Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 6, 1959

22c. NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery

22d. LOCATION (City, town, or county) (State): Hyndman, Pennsylvania

23. FUNERAL DIRECTOR'S SIGNATURE: Harvey H. Leigler, ADDRESS: Hyndman, Pa.

24a. REC'D BY REGISTRAR DATE: MAR 10 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2509 CERTIFICATE OF DEATH

02501
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY ALLEGANY
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY ALLEGANY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND

c. LENGTH OF STAY IN 1b
38 DAYS

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 CUMBERLAND

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SACRED HEART HOSPITAL

d. STREET ADDRESS
50 WEMPE DRIVE

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: HELEN Middle: Last: BERKENBAUGH

4. DATE OF DEATH Month: MARCH Day: 26 Year: 19 59

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 26, 1877

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY
Own Home

11. BIRTHPLACE (State or foreign country)
McPekin, MARYLAND

12. CITIZEN OF WHAT COUNTRY?
USA

13. FATHER'S NAME
JAMES BERRANY (DECEASED)

14. MOTHER'S MAIDEN NAME
CATHERINE Kane

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO

16. SOCIAL SECURITY NO.
none

17. INFORMANT Address
PATIENTS CHART

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

DUE TO (b): Right Cerebral Haemorrhage — 5 wks

DUE TO (c): Arteriosclerosis — 7 yrs

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 17, 19 59, to Mar 26, 19 59, that I last saw the deceased alive on Mar. 25, 19 59, and that death occurred at 12:25 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clay E. Durrett M.D. ADDRESS (Street, city or town, state): 236 Va. Ave Cumberland, Md. DATE SIGNED: 3/26/59

PHYSICIAN'S NAME (Type): Clay E. Durrett M.D. 236 Va. Avenue, Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Mar 30, 1959	St. Mary's Catholic Cem	Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2510

02502 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 30 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: BOWMANS ADDITION
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY — Middle D. — Last BONNER

4. DATE OF DEATH: Month March — Day 1, — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 21, 1911

9. AGE (In years last birthday): 47 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carmans Helper

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. R.R.

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILBERT BONNER

14. MOTHER'S MAIDEN NAME: ARBELLA SMITH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220 10 1212

17. INFORMANT — Address: MAE BONNER, BOWMANS ADDITION, CUMB. MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

DUE TO (b): Coronary Sclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Benedict Skitarelic

DATE SIGNED: 3/2/1959

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: Mar. 4, 1959

22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2587 **CERTIFICATE OF DEATH** 02503

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Lonaconing
d. STREET ADDRESS: Gills Hill
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: R. — Last: Bradley

4. DATE OF DEATH: Month: March — Day: 31 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov 22, 1893

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Celenease Worker
10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lonaconing, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Bradley

14. MOTHER'S MAIDEN NAME: Martha Metz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): 1st W.W.

16. SOCIAL SECURITY NO.: 217-03-2157

17. INFORMANT: Mrs. John Bradley "Wife" — Address: Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary arteriosclerosis — years
DUE TO
(c): Generalized arteriosclerosis — years

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 1957 19____ to March 31, 1959, that I last saw the deceased alive on Feb 28, 1959, and that death occurred at 9 a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Leslie R. Miles Jr. M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 3-31-59

PHYSICIAN'S NAME (Type): Leslie R. Miles Jr M.D. Lonaconing, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/3/59
22c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery
22d. LOCATION (City, town, or county) (State): Moscow, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: George Eichhorn
ADDRESS: Lonaconing, Md.

24a. REC'D BY REGISTRAR DATE: APR 6 '59
24b. REGISTRAR'S SIGNATURE: Cutting S Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2571

02504 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 266 E. Main Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 266 E. Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Katherine — Middle: — Last: Brady

4. DATE OF DEATH: Month: 3 — Day: 26 — Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-15-1872

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Eckhart, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Patrick Brady

14. MOTHER'S MAIDEN NAME: Honora Kenny

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Joseph Spates, 270 E. Main, Address: Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W M McLane M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): W O McLane MD asst
DATE SIGNED: Mar 27 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-30-59

22c. NAME OF CEMETERY OR CREMATORY: St. Michaels Cemetery

22d. LOCATION (City, town, or county) (State): Frostburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Beulah H. Montevert
ADDRESS: Hafer Funeral Home, 23 E. Main, Frostburg, Md.

24a. REC'D BY REGISTRAR: DATE APR 2 '59

24b. REGISTRAR'S SIGNATURE: Arthur L Thomas

VS. A15ME
8M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2572 — Reg. Dist. No. 02503

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 19 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mount Savage
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: — Last: Bridges

4. DATE OF DEATH: Month: Mar — Day: 13 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar 12 1959

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 19 — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mount Savage Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Donald Bridges

14. MOTHER'S MAIDEN NAME: Theresa Beeman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Theresa Bridges — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity 2 lb 10 oz — INTERVAL BETWEEN ONSET AND DEATH: 19 hrs
DUE TO
776 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 12, 1959, to Mar 13, 1959, that I last saw the deceased alive on Mar 13, 1959, and that death occurred at 6:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm C Lane M.D. — ADDRESS (Street, city or town, state): Frostburg Md — DATE SIGNED: Mar 14 1959

PHYSICIAN'S NAME (Type): Wm C Lane MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 3-14-59 — 22c. NAME OF CEMETERY OR CREMATORY: Porter Cemetery — 22d. LOCATION (City, town, or county) (State): Eckhart Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hafer Funeral Home 23 E. Main, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: MAR 19 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur L Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1000173XVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2511

Reg. Dist. No. 00506

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 50 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 61 Greene St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 61 Greene St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle ALVIN — Last BRILL

4. DATE OF DEATH: Month March — Day 5 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 25, 1881

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Kirby, W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William A. Brill

14. MOTHER'S MAIDEN NAME: Marian Saville

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214 05 5894

17. INFORMANT: Arthur Brill — Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary occlusion — Interval between onset and death: 1 hour
DUE TO
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) arteriosclerotic heart disease — 1 Year
DUE TO
(c) generalized arteriosclerosis — 3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Left hand by amputated (middle finger) due to arteriosclerotic gangrene

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-3-, 19 59, to 3-5-, 19 59, that I last saw the deceased alive on 3-4-, 19 59, and that death occurred at 4 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L Brill M.D. — ADDRESS (Street, city or town, state): 57 Greene St. Cumberland Md — DATE SIGNED: 3-6-59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/9/1959

22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md

24a. REC'D BY REGISTRAR DATE: MAR 9 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Brand

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS A1S (4)
15M 9/SS

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02507

Reg. Dist. No. 2512

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
Sacred Heart Hospital
c. LENGTH OF STAY IN 1b: 10 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 507 Oldtown Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NORA Middle E. Last BRINKER
4. DATE OF DEATH: Month MARCH Day 22 Year 1959
5. SEX: female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Magnolia, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Boxell
14. MOTHER'S MAIDEN NAME: Catherine Farrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: Mrs. Kenneth Roby, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema and Congestion — INTERVAL BETWEEN ONSET AND DEATH: 2-3 Wks.
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary Sclerosis — ------
DUE TO
(c) Arteriosclerotic Cardiovascular disease, generalized

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of Left Hip
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell at home
20c. TIME OF INJURY Hour 11:00 a. m. Month, Day, Year 12/30 1958
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Cumberland, Alleg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
DATE SIGNED: March 22, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-35-59
22c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cem.
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli, Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: MAR 24 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02508

CERTIFICATE OF DEATH

Reg. Dist. No.

2573

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest tawn): Frostburg
c. LENGTH OF STAY IN 1b: 2 Weeks
d. NAME OF HOSPITAL (If nat in haspital, give street address) OR INSTITUTION: Miner's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn): X Eckhart
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle W. — Last Broadwater

4. DATE OF DEATH: Month March — Day 17th, — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 27th, 1876

9. AGE (In years lost birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.-Laborer

10b. KIND OF BUSINESS OR INDUSTRY: W.P.A.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Broadwater

14. MOTHER'S MAIDEN NAME: Mary Custer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-18-2704

INFORMANT Address: Mrs. Harry Haberlein, Eckhart, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 20 yrs ?
DUE TO
422.1
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factary, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/2/59, 19__, to 3/17/59, 19__, that I last saw the deceased alive an 3/17/59, 19__, and that death accurred at 1:30 P.M. fram the causes and an the date stated abave.

ACTUAL SIGNATURE: Martin M. Rothstein M.D. — ADDRESS (Street, city ar tawn, state): 48 Broadway, Frostburg, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Martin M. Rothstein, M.D. " " " "

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-19-59

22c. NAME OF CEMETERY OR CREMATORY: Robison Cemetery

22d. LOCATION (City, town, or caunty) (State): Garrett County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Joseph R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: MAR 20 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02509

Reg. Dist. No. 2574

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 1 Wk.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Midlothian
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ollie; Middle:; Last: Cecil

4. DATE OF DEATH: Month: 3; Day: 19; Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-10-1907

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Alabama

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Robertson

14. MOTHER'S MAIDEN NAME: Ada Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.:

17. INFORMANT: William Cecil, Midlothian, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Influenza —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/12/59, 19____, to 3/19/59, 19____, that I last saw the deceased alive on 3/19/59, 19____, and that death occurred at 9:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin M. Rothstein M.D.
ADDRESS (Street, city or town, state): 48 BROADWAY
DATE SIGNED:
PHYSICIAN'S NAME (Type): MARTIN M. ROTHSTEIN MD FROSTBURG - MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/21/59
22c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park
22d. LOCATION (City, town, or county): Frostburg (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Beulah H. Montevant
ADDRESS: Hafer Funeral Home 23 E. Main, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: MAR 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Adams

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2513 CERTIFICATE OF DEATH

Reg. Dist. No. 02510

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: VINE PLACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
EMMA	M.	CHISHOLM	MARCH	3	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE		July 26, 1885	73 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN RIEHL	MARTHA RUMPF

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	218-16-4681A	John F. Chisholm	Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Anteroseptal myocardial Infarction, recent, with congestive heart failure	2 weeks
DUE TO (b)	Arteriosclerotic Heart Disease with cardiomegaly	years
DUE TO (c)		

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Genitourinary tract infection

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]

20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from February 15, 1959, to March 3rd, 1959, that I last saw the deceased alive on March 3rd 1959, and that death occurred at 5:25 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Wyand F. Doerner Jr. M.D. ADDRESS (Street, city or town, state): Algonquin Hotel, Cumberland, Md. DATE SIGNED:

PHYSICIAN'S NAME (Type): Wyand F. Doerner, Jr., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3/6/59	RoseHill Cemetery	Cumberland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Ruth E. Silcox	Cumberland Maryland	MAR 9 '59	Clifford S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2514

CERTIFICATE OF DEATH

02511
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 11 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 114 SEYMOUR ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH Middle Peter Last CODIRE

4. DATE OF DEATH: Month MARCH Day 30 Year 19 59

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY 28, 1920
9. AGE (In years last birthday): 38 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNEMPOYED
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: PETER M. CODIRE (DECEASED)
14. MOTHER'S MAIDEN NAME: REGINA MCHUGH CODIRE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
INFORMANT: PATIENTS CHART — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 340.3 meningitis — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-29, 19 59, to 3-30, 19 59, that I last saw the deceased alive on 3-29, 19 59, and that death occurred at 8:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L Brings M.D.
ADDRESS (Street, city or town, state): 57 Greene St.
DATE SIGNED: 3-30-59

PHYSICIAN'S NAME (Type): LEWIS BRINGS, M.D. — 57 GREENE ST., CUMBERLAND, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-2-59
22c. NAME OF CEMETERY OR CREMATORY: St. Patrick Cem.
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: APR 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2515

CERTIFICATE OF DEATH

02512
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 114 Winton Place

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland,
d. STREET ADDRESS: 114 Winton Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harriet; Middle: Elizabeth; Last: Cooper

4. DATE OF DEATH: Month: March; Day: 5; Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 8, 1878

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Harman, W. Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jacob C. Harper

14. MOTHER'S MAIDEN NAME: Susan McDonald

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Walter M. Fuller — Address: Cumberland, 420 Beall St., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hour
DUE TO
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic heart disease — 1 year
DUE TO
(c) generalized arteriosclerosis — 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-4, 1959, to 3-5, 1959, that I last saw the deceased alive on 3-5, 1959, and that death occurred at 4:10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L Brings M.D.
ADDRESS (Street, city or town, state): 57 Greene St.,
DATE SIGNED:

PHYSICIAN'S NAME (Type): Lewis Brings M.D. — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/7/59
22c. NAME OF CEMETERY OR CREMATORY: Harper Cemetery
22d. LOCATION (City, town, or county) (State): Harman, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: MAR 9 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2516 **CERTIFICATE OF DEATH** Reg. Dist. No. 02513

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 14 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 633 MARYLAND AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIAN Middle PEARL Last CORNWELL

4. DATE OF DEATH: Month MARCH Day 7 Year 19 59

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 8, 1893

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: IRA THOMAS HITE

14. MOTHER'S MAIDEN NAME: EMMA FADLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 days
DUE TO
(b): Coronary Artery Disease
DUE TO
(c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/20/59, 19____, to 3/7/59, 19____, that I last saw the deceased alive on 3/7/59, 19____, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: B. F. Childress M.D. ADDRESS (Street, city or town, state): Cumberland Md DATE SIGNED: 3/9/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial 22b. DATE THEREOF: 3/10/59 22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park 22d. LOCATION (City, town, or county) (State): Cumberland Md

23. FUNERAL DIRECTOR'S SIGNATURE: Ruth E. Silcox ADDRESS: Cumberland Maryland

24a. REC'D BY REGISTRAR DATE: MAR 11 '59 24b. REGISTRAR'S SIGNATURE: Clinton L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2575 — Reg. Dist. No. 02514

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Lonaconing
d. STREET ADDRESS: Watercliffe
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: — Last: Cuthbertson

4. DATE OF DEATH: March — Day: 19 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: July 19, 1900

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Celanese Worker
10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp
11. BIRTHPLACE (State or foreign country): Lonaconing, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Cuthbertson
14. MOTHER'S MAIDEN NAME: Elizabeth Park

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown; If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 220-10-2356H
17. INFORMANT — Address: Mrs. William Cuthbertson "Wife" Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Mesenteric Thrombosis	1 week
DUE TO (b)	Recurrant Phlebitis	3 years
DUE TO (c)	Agnogenic Myeloid Metaplasia	7 years

292.3

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 19 56 to March 19 59, that I last saw the deceased alive on March 19 59, and that death occurred at 9 P M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) — DATE SIGNED

ACTUAL SIGNATURE: Leslie R. Milles Jr. M.D. — 3-20-59

PHYSICIAN'S NAME (Type): LESLIE R. MILLES JR — LONACONING — MD

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3/22/59	Oak Hill Cemetery	Lonaconing, Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	MAR 23 '59	Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG240 3-20-59 et

CERTIFICATE OF DEATH

2517 Items 8,9 FilmG240 4-6-59 et

02515 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 119 Bedford ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 119 Bedford ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Louis — Last: Davids

4. DATE OF DEATH: Month: March — Day: 11 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 26 1889

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Eng. in Ordnance Dept

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Army

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Davids

14. MOTHER'S MAIDEN NAME: Elizabeth Kehrn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 578-32-8777

17. INFORMANT: Elva M. Davids — Address: 119 Bedford St. Cumberland Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Years

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 5, 19 59 to Mar. 11, 19 59 that I last saw the deceased alive on Mar. 10, 19 59, and that death occurred at 5:00 A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clay F. Smith M.D. ADDRESS (Street, city or town, state): 236 Va. Ave Cumberland Md. DATE SIGNED: 3/13/59

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar. 13, 1959

22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Louis Stein Inc. Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: MAR 16 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02516

2576

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
o. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 10 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miner's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN. (If outside corporate limits, write RURAL and give nearest town): X R.D. 3, Frostburg, Box 61
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary — Middle C. — Last Delaney
4. DATE OF DEATH: Month March — Day 18th, — Year 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 4th, 1891
9. AGE (In years lost birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Housework
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Reilly
14. MOTHER'S MAIDEN NAME: Sarah Malloy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-01-3657A
INFORMANT Address: John A. Delaney, RD 3, F'bg., Md. Box 61

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma Descendig Colon — INTERVAL BETWEEN ONSET AND DEATH: 6 years
153.2
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/8, 19 59, to March 18, 19 59 that I last saw the deceased alive on March 18, 19 59, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Hilda Jane Walters M.D.
ADDRESS (Street, city or town, state): 48 Broadway, Frostburg, Md.
DATE SIGNED: 3/20/59

PHYSICIAN'S NAME (Type): Hilda Jane Walters, M.D. " " "

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-21-59
22c. NAME OF CEMETERY OR CREMATORY: St. Michael's Cemetery
22d. LOCATION (City, town, or county) (State): Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Joseph R. Durst, Frostburg, Md.
24a. REC'D BY REGISTRAR DATE: MAR 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02517
Reg. Dist. No.

2518

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 24 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 456 Williams St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JESSE — Middle EARL — Last DeVORE
4. DATE OF DEATH: Month March — Day 16 — Year 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 8, 1882
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Signalman
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John DeVore
14. MOTHER'S MAIDEN NAME: Barbara Witt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 705 05 1809
17. INFORMANT: Mrs. Sarah DeVore — Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4-5 days
420.1
DUE TO (b): Arteriosclerotic C-V Disease — ----
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of left hip
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell At Home
20c. TIME OF INJURY: Hour 2:15 p. m. — Month, Day, Year 3/8/59 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Cumberland, Alleg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Benedict Skitarelic M. D.
DATE SIGNED: March 17, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/18/1959
22c. NAME OF CEMETERY OR CREMATORY: Hilcrest Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: MAR 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG240 3-30-59 et

2519

CERTIFICATE OF DEATH

02518 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pinto, Md Cumberland
c. LENGTH OF STAY IN 1b: 24 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital-D.O.A. Allegany/Ballistics

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 407 Linden Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Reese; Middle: Irvin; Last: Diehl

4. DATE OF DEATH: Month: March; Day: 18; Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 1, 1908

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone installer-

10b. KIND OF BUSINESS OR INDUSTRY: Cumberland, Md

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank I. Diehl

14. MOTHER'S MAIDEN NAME: Carrie Mae Robertson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-05-0785

17. INFORMANT: Mrs. Marie Diehl [redacted] Address: 407 Linden, St. Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO (b): Coronary artery disease

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Duodenal ulcer.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 24, 1957, to 3-18-59, that I last saw the deceased alive on 3-14-59, and that death occurred at 10 a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. L. Williams M.D.

ADDRESS (Street, city or town, state): Cumberland Md

DATE SIGNED: 3/18/59

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/21/59

22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

22d. LOCATION (City, town, or county) (State): Cumberland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ruth E. Silcox

ADDRESS: Cumberland Maryland

24a. REC'D BY REGISTRAR DATE: MAR 23 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG240 3-24-59 et

CERTIFICATE OF DEATH

2577

02519 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
c. LENGTH OF STAY IN 1b: 4 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 135 Front

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
d. STREET ADDRESS: 135 Front
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Verna Middle: Mae Last: Doman

4. DATE OF DEATH: Month: Mar. Day: 18 Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 5, 1901

9. AGE (In years last birthday): 57 DP yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.a.

13. FATHER'S NAME: Joseph S. Teets

14. MOTHER'S MAIDEN NAME: Rebecca Hutzel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Howard Doman—Westernport, Md. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Uterus and Rectum — INTERVAL BETWEEN ONSET AND DEATH: 12 yrs
199.2
DUE TO
(b): Carcinomatosis., — 5yrs
Conditions, if any, which gave rise to immediate couse (a), stoling the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 28, 19 58 to Mch 18, 19 59 that I last saw the deceased alive on Mch. 18, 19 59, and that death occurred at 5.10 AM pm, from the causes and on the date stated above.

ACTUAL SIGNATURE: H H Wolverton Sr M.D. ADDRESS (Street, city or town, state): Piedmont W Va DATE SIGNED:

PHYSICIAN'S NAME (Type): James H. Wolverton Sr Md Piedmont W Va

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/21/59

22c. NAME OF CEMETERY OR CREMATORY: George Cemetery

22d. LOCATION (City, town, or county): Swanton (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: E. L. Bruce ADDRESS: Westernport, Md.

24a. REC'D BY REGISTRAR DATE: MAR 20 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krusa

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02520
Reg. Dist. No.

2520

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 117 Independence St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 117 Independence St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle M — Last EIRICH

4. DATE OF DEATH: Month MARCH — Day 27 — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 26,1909
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY: Bakery
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles L. Eirich
14. MOTHER'S MAIDEN NAME: Emma Crutchley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214 05 9296
17. INFORMANT — Address: Mrs. Inez Eirich Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3-4 days
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary Occlusion, right — 3-4 days
DUE TO
(c) Coronary Sclerosis, right

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary embolism from mural thrombus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour — o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: March 27, 1959
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/30/1959
22c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery
22d. LOCATION (City, town, or county) (State): Moorefield, W/ Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: MAR 31 '59
24b. REGISTRAR'S SIGNATURE: Clifton L. Knaus

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G240, 3/23/59, fcy

02521

CERTIFICATE OF DEATH

2578

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 125 East Main

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 125 E. Main
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nellie; Middle: V.; Last: Fisher

4. DATE OF DEATH: Month: 3; Day: 14; Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-10-1874

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Eckhart, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John A. McMullen

14. MOTHER'S MAIDEN NAME: Mary V. Jordan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Jackson Fisher, Consolidation Village
Address: Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac dilitation — INTERVAL BETWEEN ONSET AND DEATH: Sudden
422.2
DUE TO
(b) Chr- myocardial insufficiency — 8-9 years
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. / p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 50, to 3-14, 19 59, that I last saw the deceased alive on 3-4, 19 59, and that death occurred at 8 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H. C. Diehl, M.D.
ADDRESS (Street, city or town, state): 39 W. MAIN ST.
DATE SIGNED: 3/17/59

PHYSICIAN'S NAME (Type): H. C. DIEHL, M.D.
FROSTBORG, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-17-59

22c. NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery

22d. LOCATION (City, town, or county): Eckhart, (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Beulah K. Montesano
ADDRESS: Hafer Funeral Home 23 E. Main, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: MAR 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2521

02522 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 314 Pulaski Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

3. NAME OF DECEASED (Type or print): First Viola — Middle M. — Last Fogtman

4. DATE OF DEATH: Month March — Day 16th — Year 1959

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan 23,

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Adam Spoerl

14. MOTHER'S MAIDEN NAME: Clara Conners

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Pt's chart- Husband

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Occlusion, Right Coronary Artery — INTERVAL BETWEEN ONSET AND DEATH: minutes
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive and Arteriosclerotic Heart
DUE TO
(c) disease, with cardiomegaly & old massive anterior myocardial infarction — 13 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute Obstruction of Sigmoid Colon, due chronic diverticulitis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 25 19 58 to March 16th 19 59, that I last saw the deceased alive on March 16th, 19 59, and that death occurred at 9:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wyand F. Doerner Jr M.D.
ADDRESS (Street, city or town, state): Algonquin Hotel,
DATE SIGNED

PHYSICIAN'S NAME (Type): Wyand F. Doerner, Jr., M.D. — Cumberland, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 19, 1959
22c. NAME OF CEMETERY OR CREMATORY: St. Peter + Paul Cem
22d. LOCATION (City, town, or county) (State): Cumberland Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Louis Stein Inc. Cumb Md

24a. REC'D BY REGISTRAR — DATE: MAR 20 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02523

2522

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X LONACONING
d. STREET ADDRESS: BOX 214
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First EDNA — Middle M — Last FOOTE

4. DATE OF DEATH: Month MARCH — Day 2 — Year 19 59

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 28, 1898

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): WESTERNPORT, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HENRY DAYTON

14. MOTHER'S MAIDEN NAME: EMMA DAWSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia, hepatic coma — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
581.0
DUE TO
(b): Portal Cirrhosis of liver — ?
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Post hemorrhagic anemia due to ruptured esophageal varices

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 1, 19 59 to March 2, 19 59, that I last saw the deceased alive on March 2, 19 59, and that death occurred at 2:25P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 50 Pershing St. — DATE SIGNED: 2/4/59

PHYSICIAN'S NAME (Type): Samuel M. Jacobson, M.D. — Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/5/59
22c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
22d. LOCATION (City, town, or county) (State): Lonaconing Md.

23. FUNERAL DIRECTOR'S SIGNATURE: George Eichhorn — ADDRESS: Lonaconing, Md.

24a. REC'D BY REGISTRAR DATE: MAR 9 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02524

2523

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 7 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Hillcrest Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Cumberland
d. STREET ADDRESS: 1 Hillcrest Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALICE — Middle GERTRUDE — Last GOODWIN

4. DATE OF DEATH: Month March — Day 15 — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: December 23, 1882
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Regestered Nurse
11. BIRTHPLACE (State or foreign country): Finzel, Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Finzel (Deceased)
14. MOTHER'S MAIDEN NAME: Sarah McKenzie (Deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Arthur Hawkins, Hillcrest Drive, Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Terminal Cardiac failure	4 days
DUE TO (b)	arteriosclerotic Heart Disease	5 years
DUE TO (c)	Generalized arteriosclerosis	?

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Parkinsons Syndrome

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 15 March, 1959, to 15 March, 1959, that I last saw the deceased alive on 15 March, 1959, and that death occurred at 5:40P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Alfred VanOrmer M.D.
ADDRESS (Street, city or town, state): 122 South Center St. Cumberland, Md.
DATE SIGNED: 3/17/59

PHYSICIAN'S NAME (Type): Alfred VanOrmer M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 18, 1959
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 19 '59
24b. REGISTRAR'S SIGNATURE: Catherine L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02525

Allegany 2524 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 66 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 43 Westernport
d. STREET ADDRESS: 104 Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Bertha; Middle: A.; Last: Griffin

4. DATE OF DEATH: Month: March; Day: 2; Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/28/1890

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house-wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Hammers

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Chart — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Squamous cell carcinoma of cervix — INTERVAL BETWEEN ONSET AND DEATH: 6 months
199.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-4, 19 59, to 3-2, 19 59, that I last saw the deceased alive on 3-2, 19 59, and that death occurred at 4:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lewis Brings, M.D. — ADDRESS (Street, city or town, state): 57 Green St. — DATE SIGNED: 3-3-59

PHYSICIAN'S NAME (Type): LEWIS BRINGS — Cumberland Md

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 3/5/59
22c. NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery
22d. LOCATION (City, town, or county) (State): Westernport, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. H. Fridley Jr. — ADDRESS: Piedmont, W.Va.

24a. REC'D BY REGISTRAR DATE: MAR 5 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02526

2525

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 20 minutes
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 310 PIEDMONT AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WALTER Middle L. Last HARDMAN

4. DATE OF DEATH: Month MARCH Day 13 Year 1959

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-17-99
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stockman
10b. KIND OF BUSINESS OR INDUSTRY: Merchants Wholesale
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA, Bedford County
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: CLINTON HARDMAN (Deceased)
14. MOTHER'S MAIDEN NAME: BESSIE Brashears HARDMAN (Deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-05-6260
17. INFORMANT: CHART Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute coronary occlusion	4 hours
DUE TO	420.1	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Coronary sclerosis	1 year
DUE TO (c)	Generalized arteriosclerosis	2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-1-58, to 3-13-59, that I last saw the deceased alive on 3-13-59, and that death occurred at 5:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L Brings M.D.
ADDRESS (Street, city or town, state): 57 Greene Street Cumberland, Md.
DATE SIGNED: 3/16/59

PHYSICIAN'S NAME (Type): LEWIS BRINGS, M.D.
57 GREEN STREET CUMBERLAND, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/16/59
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Prk
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland
24a. REC'D BY REGISTRAR DATE: MAR 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG240 3-24-59 et

CERTIFICATE OF DEATH

2526

02527
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b L DAY
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
d. STREET ADDRESS 823 LAFAYETTE AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JOHN	W	HARE	MARCH	15	19 59

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE		Oct. 4, 1884	74 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Park Police	City of Cumberland	WEST VIRGINIA Martinsburg	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
THOMAS HARE	NANCY DYCKE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	214-05-9234	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Anaemia	3 wks
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Carcinoma of Thyroid	4 yrs
DUE TO (c)	Secondary Anaemia	4 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 10, 19 59 to Mar 15, 19 59, that I last saw the deceased alive on 3/15, 19 59, and that death occurred at 1:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Chas R Lovett M.D. ADDRESS (Street, city or town, state) 236 Va. Ave Cumberland DATE SIGNED 3/18/59

PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3-18-59	Wesley Chapel	Points, W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
James F. Scarpelli Cumberland, Md.	MAR 19 '59	Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2527

CERTIFICATE OF DEATH

02528
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 38 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL, MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 71 GREENE ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MR. Middle Newton B. Last HEIMS

4. DATE OF DEATH: Month MARCH Day 1 Year 19 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/25/80

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Proprietor

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES Heims

14. MOTHER'S MAIDEN NAME: CLARA Leedy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease with cardiomegaly, old myocardial infarct, congestive failure and myocardial degeneration — INTERVAL BETWEEN ONSET AND DEATH: several yrs

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Pyelonephritis with early uremia; Occlusion, rt. popliteal art.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1958, to March 1, 1959, that I last saw the deceased alive on March 1st, 1959, and that death occurred at 12;10P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wyand R. Doerner Jr M.D.
ADDRESS (Street, city or town, state): Algonquin Hotel
DATE SIGNED:

PHYSICIAN'S NAME (Type): DR. WEYAND DOERNER ALGONQUIN HOTEL, CUMBERLAND, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/3/59
22c. NAME OF CEMETERY OR CREMATORY: Umbria Cemetery
22d. LOCATION (City, town, or county) (State): Osceola Mills, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George
ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: MAR 4 '59
24b. REGISTRAR'S SIGNATURE: Cirthus L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2579

CERTIFICATE OF DEATH

02529
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fros tburg
c. LENGTH OF STAY IN 1b: 3 Mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miner's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Savage
d. STREET ADDRESS: Glen Savage Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma; Middle: C.; Last: Henckel

4. DATE OF DEATH: Month: March; Day: 13th; Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 18th, 1873

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: own housework

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Valentine Henckel

14. MOTHER'S MAIDEN NAME: Catherine Snyder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT Address: Miss Edna Henckel, Mt. Savage, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
331x
DUE TO (b): Arterio Sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 2 or 3 Several years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 12, 1958, to March 13, 1959, that I last saw the deceased alive on Mar 13, 1959, and that death occurred at 7:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W O McLane M.D.
ADDRESS (Street, city or town, state): E. Main St., Frostburg, Md.
DATE SIGNED: Mar 13, 1959

PHYSICIAN'S NAME (Type): W. O. McLane, M.D. " " " "

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-16-59
22c. NAME OF CEMETERY OR CREMATORY: St. Patricks Cemetery
22d. LOCATION (City, town, or county) (State): Mt. Savage, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Joseph R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: MAR 17 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Young

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02530

2528

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 8/5/58
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaVale
d. STREET ADDRESS: 2 Oaklawn Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: A. — Last: Hendrickson

4. DATE OF DEATH: Month: March — Day: 15, — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/10/1875

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Foreman

10b. KIND OF BUSINESS OR INDUSTRY: Md. State Roads

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: WILLIAM HENDRICKSON

14. MOTHER'S MAIDEN NAME: MARTHA HUFF

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: P.O.Box 599 Allegany County Infirmary Records — Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: ?

420.1

DUE TO

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

(b) DUE TO: Chronic Myocardial Degeneration — ?

(c): Cerebral Arteriosclerosis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile Deterioration

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/5/58, 19____, to 3/15/59, 19____, that I last saw the deceased alive on 3/14/59, 19____, and that death occurred at 5:30P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean M.D. — ADDRESS (Street, city or town, state): 49 Greene St. — DATE SIGNED: 3/16/59

PHYSICIAN'S NAME (Type): Dr. James E. McLean — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/18/59

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2529 — 02531 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 407 Beall St.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland,
d. STREET ADDRESS: 407 Beall St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annette — Middle: — Last: Hensel
4. DATE OF DEATH: Month: MARCH — Day: 1, — Year: 19 59
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 13, 1879
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Linen folder
10b. KIND OF BUSINESS OR INDUSTRY: Hosp. Laundry
11. BIRTHPLACE (State or foreign country): Leisenring, Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Hensel
14. MOTHER'S MAIDEN NAME: Ann Prinkey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. C. F. Purdham, Address: 5009 54th Rogers Hyattsville, Md. Hts

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
420.1
DUE TO (b): CORONARY SCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: March 3, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/6/59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olive Cemetery
22d. LOCATION (City, town, or county) (State): Connellsville, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: MAR 6 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2530

02532 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland Maryland
c. LENGTH OF STAY IN 1b: 5 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland, Maryland
d. STREET ADDRESS: 210 Knox St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: E. — Last: Higgins

4. DATE OF DEATH: Month: March — Day: 22nd — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-1-1885

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired School Principal

10b. KIND OF BUSINESS OR INDUSTRY: Public Schools

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S. A.

13. FATHER'S NAME: James Higgins

14. MOTHER'S MAIDEN NAME: Mary Douglas Higgins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Charles Marks — Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic and coronary heart disease — INTERVAL BETWEEN ONSET AND DEATH: 6 years
420.1
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3 - 18, 19 57 to 3 - 22, 19 59 that I last saw the deceased alive on 3 - 22 -, 19 59, and that death occurred at 1:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Roger W. Ballin M.D. — ADDRESS (Street, city or town, state): 62 Greene St. — DATE SIGNED: 3-23-59

PHYSICIAN'S NAME (Type): Dr. R. W. Ballin — 62 Greene St. Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/25/1959

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: MAR 26 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02533

2588

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eckhart
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Eckhart
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna — Middle: S. — Last: Himmelwright

4. DATE OF DEATH: Month: March — Day: 14th, — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 5th, 1879

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hous ewife

10b. KIND OF BUSINESS OR INDUSTRY: own Housework

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis Kimberley

14. MOTHER'S MAIDEN NAME: Lucinda Porter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT Address: Mrs.Ruth Snyder, Eckhart, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): arteriosclerosis
DUE TO (b): Cerebral Hemorrhage
DUE TO (c):

331X

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

INTERVAL BETWEEN ONSET AND DEATH: 6 mo

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 16, 1957, to March 14, 1959, that I last saw the deceased alive on Feb 21, 1959, and that death occurred at 9:20 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: W O McLane M.D.

ADDRESS (Street, city or town, state): 167 E. Main St.,F'bg.,Md.

DATE SIGNED: March 16 1959

PHYSICIAN'S NAME (Type): W. O. McLane, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-17-59

22c. NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery

22d. LOCATION (City, town, or county) (State): Eckhart, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Joseph R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: MAR 17 '59

24b. REGISTRAR'S SIGNATURE: Ashley L. Knox

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2531 Reg. Dist. No. 02534

1. PLACE OF DEATH
a. COUNTY: Allegany MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 5/20/57

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Frostburg
d. STREET ADDRESS: Rt.#1, Vale Summit
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

3. NAME OF DECEASED (Type or print): First Crawford Middle S. Last Hoblitzell
4. DATE OF DEATH: Month March Day 22, Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/22/1874
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Coal Mining & Store Clerk
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Frostburg, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William S. Hoblitzell
14. MOTHER'S MAIDEN NAME: Margaret P. Shearer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: P.O.Box 599, Allegany County Infirmary Records Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1
(b) Chronic Myocardial Degeneration — ?
DUE TO
(c) Cerebral Arteriosclerosis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchial Asthma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/20/57, 19____, to 3/22/59, 19____, that I last saw the deceased alive on 3/21/59, 19____, and that death occurred at 12:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean M.D. ADDRESS (Street, city or town, state): 49 Greene St. DATE SIGNED: 3/23/59
PHYSICIAN'S NAME (Type): Dr. James E. McLean Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-24-59
22c. NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park
22d. LOCATION (City, town, or county) (State): Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Joseph R. Durst, Frostburg, Md.
24a. REC'D BY REGISTRAR DATE: MAR 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2532 **CERTIFICATE OF DEATH** Reg. Dist. No. 02535

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 119 Polk St.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland,
d. STREET ADDRESS: 1 119 Polk St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Bernadette Middle Veronica Last Hoenicka
4. DATE OF DEATH: Month March Day 13, Year 19 59
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 25, 1889
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James McKenzie
14. MOTHER'S MAIDEN NAME: Sarah McKenzie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. Reid C. Hoenicka Address: 119 Polk St., Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO
(b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 1958, to Mar. 13, 1959, that I last saw the deceased alive on Mar. 13, 1959, and that death occurred at 9:40P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Leo H. Ley Jr M.D.
ADDRESS (Street, city or town, state): 456 N. Centre St. Cumberland, Md.
DATE SIGNED: 3/17/59
PHYSICIAN'S NAME (Type): LEO H. LEY JR.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/16/59
22c. NAME OF CEMETERY OR CREMATORY: St. Patrick's Cem.
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: MAR 17 '59
24b. REGISTRAR'S SIGNATURE: Arthur E. Krouse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2533

Reg. Dist. No. 02536

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Lonaconing
d. STREET ADDRESS: Hanekamp
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edith — Middle — Last Holder

4. DATE OF DEATH: Month March — Day 31 — Year 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 27, 1889

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary

10b. KIND OF BUSINESS OR INDUSTRY: Office Work

11. BIRTHPLACE (State or foreign country): Lonaconing, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert Holder

14. MOTHER'S MAIDEN NAME: Ann Bowden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Ella Braznelle "Sister" Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the lung, — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO: alveolar type
163X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): —
DUE TO
(c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/15, 19 59, to 3/31, 19 59 that I last saw the deceased alive on 3/31, 19 59, and that death occurred at 2 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: George Vach, M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type): George Vach

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/3/59

22c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery

22d. LOCATION (City, town, or county) (State): Lonaconing, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: George Eichhorn — ADDRESS: Lonaconing, Md.

24a. REC'D BY REGISTRAR DATE: APR 6 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2534 — Reg. Dist. No. 02537

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 21 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 1 512 HILL STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle SCOTT XX — Last HOLLINGSWORTH
4. DATE OF DEATH: Month MARCH — Day 9 — Year 19 59

5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. MARRIED XXX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JUNE 1, 1889
9. AGE (In years last birthday) XX XX 69 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Bell Hop
10b. KIND OF BUSINESS OR INDUSTRY: Windsor Hotel
11. BIRTHPLACE (State or foreign country): MOOREFIELD, W.VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM HOLLINGSWORTH
14. MOTHER'S MAIDEN NAME: BERTHA WILLIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-16-2667
17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
420.1
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b): Arteriosclerosis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Gangrene - both Feet
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-16, 19 59, to 3-9, 19 59, that I last saw the deceased alive on 3-9, 19 59, and that death occurred at 10:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William R James M.D. — ADDRESS (Street, city or town, state): 441 N Centre St — DATE SIGNED: 3-10-59
PHYSICIAN'S NAME (Type): William R James — Cumberland, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/12/59
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Mun. Park
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John J. Hafer, Cumberland, Maryland
24a. REC'D BY REGISTRAR — DATE: MAR 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film C239 3-16-59 et

2535

CERTIFICATE OF DEATH

02538 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1. PLACE OF DEATH a. COUNTY: Allegany	MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland	c. LENGTH OF STAY IN 1b: 4/6/56
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland	b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cresaptown	
d. STREET ADDRESS: Along Rt. # 220	e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First Bertie Middle H. (Willison) Last Howe	4. DATE OF DEATH: Month March Day 10 Year 1959
5. SEX: Female	6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 6/6/1876
9. AGE (In years last birthday): 82 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Proprietor	10b. KIND OF BUSINESS OR INDUSTRY: Wall Paper Bus.
11. BIRTHPLACE (State or foreign country): Cumberland, Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Andrew Topper	14. MOTHER'S MAIDEN NAME: Hannah Waldron
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 705-09-3513
17. INFORMANT: P.O.Box 599 Allegany County Infirmary Records	Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary Hypostasis	72 Hrs
DUE TO (b)	Cerebral arteriosclerosis	?
DUE TO (c)	Cerebral Hemorrhage	?

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rt. Hemiplegia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/6/56, 19__ to 3/10/59, 19__, that I last saw the deceased alive on 3/9/59, 19__, and that death occurred at 12:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean M.D. — ADDRESS (Street, city or town, state): 49 Green Street — DATE SIGNED: 3/10/59

PHYSICIAN'S NAME (Type): Dr. James E. McLean — Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 3/12/59	22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State): Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Charles L. George Cumberland, Md.		24a. REC'D BY REGISTRAR DATE: MAR 16 '59	24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2580

CERTIFICATE OF DEATH

Reg. Dist. No. 02539

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 3days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. STREET ADDRESS: High Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PHOEBE Middle ELLEN Last HUMPHREY

4. DATE OF DEATH: Month March Day 18th. Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 27, 1879
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Rawlings, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Sheppard
14. MOTHER'S MAIDEN NAME: Margaret Carter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Sarah Harris (DAUGHTER) Address: Frostburg, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Ischemia & failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Cardio-vascular disease — years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1956, to March, 1959, that I last saw the deceased alive on March 18, 1959, and that death occurred at 8 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Leslie R. Miles M.D.
ADDRESS (Street, city or town, state): LONACONING MD
DATE SIGNED: 3-20-59
PHYSICIAN'S NAME (Type): LESLIE R. MILES JR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/21/1959
22c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
22d. LOCATION (City, town, or county) (State): Lonaconing, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN ADDRESS: LONACONING, MD.
24a. REC'D BY REGISTRAR DATE: MAR 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur J. Keen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2536

CERTIFICATE OF DEATH

02540 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 3/10/59
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × Spring Gap
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Stella; Middle: A.; Last: Irons

4. DATE OF DEATH: Month: March; Day: 12,-; Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 11, 1897

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Border Erison

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Husband Earl Irons, SpringGap Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anaemia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
422.1
DUE TO
(b): Myocarditis & Decompensation — 1 yr
DUE TO
(c): Arteriosclerosis — 5 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1956 to Mar 12, 1959, that I last saw the deceased alive on Mar 12, 1959, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clay E. Durrett M.D. — ADDRESS (Street, city or town, state): 236 Va. Ave Cumberland — DATE SIGNED: 3/14/59

PHYSICIAN'S NAME (Type): Clay E. Durrett M.D. — 236 Virginia Avenue, Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/15/59
22c. NAME OF CEMETERY OR CREMATORY: Davis Mem. Meth. Cemetery
22d. LOCATION (City, town, or county) (State): Allegany County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 19 '59

24b. REGISTRAR'S SIGNATURE: Curtis S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2581 — Reg. Dist. No. 02541

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 16 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miner's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 302 Welsh Hill
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: A. — Last: Kear
4. DATE OF DEATH: Month: 3 — Day: 14 — Year: 19 59
5. SEX: Male
6. COLOR OR RACE: W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/5/1880
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Mail Carrier
10b. KIND OF BUSINESS OR INDUSTRY: U.S. PostOffice
11. BIRTHPLACE (State or foreign country): Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Kear
14. MOTHER'S MAIDEN NAME: Cinderella Ferry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. WM. A. Kear, 302 Welsh Hill. — Address: Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma Ascending Colon — INTERVAL BETWEEN ONSET AND DEATH: 3 Mo
153.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Myocardial Insufficiency — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 4, 19 58 to Mar 14, 19 59, that I last saw the deceased alive on Mar 14, 1959, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W O McLane M.D. — ADDRESS (Street, city or town, state): Frostburg — DATE SIGNED: Mar 16 1959
PHYSICIAN'S NAME (Type): W O McLane MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-17-59
22c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park, Frostburg
22d. LOCATION (City, town, or county) (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ernest H. Hartsuff — ADDRESS: Hafer Funeral Home, 23 E. Main, Frostburg, Md.
24a. REC'D BY REGISTRAR DATE: MAR 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2537 CERTIFICATE OF DEATH

02542
Reg. Dist. No.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cumberland
d. STREET ADDRESS: Rt. 5, Winchester Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: William — Last: Kelly

4. DATE OF DEATH: Month: March — Day: 22, — Year: 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: April 13, 1880

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Janitor

10b. KIND OF BUSINESS OR INDUSTRY: Apt. Houses

11. BIRTHPLACE (State or foreign country): PA. Somerset County

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Kelly

14. MOTHER'S MAIDEN NAME: Anna[illegible] Emerick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-10-7987

17. INFORMANT Address: Mrs. Alberta Lease, Rt # 5 Winchester Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	apoplectic stroke	2 days
DUE TO (b)	cerebral arteriosclerosis	2 yrs
DUE TO (c)	generalized arteriosclerosis	2 yrs

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-2, 19 58, to 3-22, 19 59, that I last saw the deceased alive on 3-22, 19 59, and that death occurred at 9 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 57 Queen St. — DATE SIGNED

PHYSICIAN'S NAME (Type): LEWIS BRINGS MD — Cumberland Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar. 25, 1959

22c. NAME OF CEMETERY OR CREMATORY: Lybarger Cemetery

22d. LOCATION (City, town, or county) (State): Madley, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Charles L. George, Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: MAR 26 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2538

02543

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: /
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 105 Frederick Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 105 Frederick Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leroy — Middle: Emerson — Last: Kimes

4. DATE OF DEATH: Month: March — Day: 15 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 15, 1883

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Druggist

10b. KIND OF BUSINESS OR INDUSTRY: Druggist

11. BIRTHPLACE (State or foreign country): Keyser W.Va.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Kimes

14. MOTHER'S MAIDEN NAME: Anna R. Mohler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-38-0086

17. INFORMANT — Address: Medical Examiner. Cumb. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b): Coronary Sclerosis — —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Benedict Skitarelic, MD
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: March 15, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 18, 1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Louis Stein Inc. Cumb. Md

24a. REC'D BY REGISTRAR DATE: MAR 20 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2539

CERTIFICATE OF DEATH

02544

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 21 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: PENNA.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - WELLERSBURG 75 X 3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JOHN	RANDOLPH	KIRBY	MARCH	10,	19 59

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE		DEC. 29	37 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SCHOOL TEACHER		MARYLAND	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
GEORGE A. KIRBY (DECEASED)	ANNA E. LEWIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
yes	II		PATIENTS CHART

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Occlusion of Coronary Artery — INTERVAL BETWEEN ONSET AND DEATH: 3 week
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-16-, 1959, to 3-10-, 1959, that I last saw the deceased alive on 3-9-, 1959, and that death occurred at 3:25A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James T. Johnson Jr. M.D. — ADDRESS (Street, city or town, state): 16 Greene St Cumberland Md — DATE SIGNED: 3/11/59

PHYSICIAN'S NAME (Type): JAMES T. JOHNSON, JR., M.D — 16 GREENE ST., CUMBERLAND, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3-14-59	Cook Cemetery	Wellersburg, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	MAR 16 '59	Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02545
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: 2540 Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
d. STREET ADDRESS: 3 Decatur St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle Evert Last KNIPPENBERG
4. DATE OF DEATH: Month March Day 4 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 1, 1876
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Maintainance man
10b. KIND OF BUSINESS OR INDUSTRY: Kelly Tire Co.
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Knippenberg
14. MOTHER'S MAIDEN NAME: Luetetia Logsdon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-10-1506A
17. INFORMANT: Mrs. Percival Twigg — Address: 1001 Church St., Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 332x Cerebellar Necrosis — Interval between onset and death: Years

DUE TO (b): Cerebral Arteriosclerosis, Marked — Years

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 2 Fractured Ribs

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Fell At County Home, Cumberland, Md.
20c. TIME OF INJURY — Hour: 5 P.M. — Month, Day, Year: March 1 1959
20d. INJURY OCCURRED — While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): County home
20f. (City or town) (County) (State): Cumberland, Alleg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
DATE SIGNED: March 4, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/7/59
22c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR: MAR 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2541

02546

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND,
c. LENGTH OF STAY IN 1b: 9 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL, MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND,
d. STREET ADDRESS: 119 S.ALLEGANY ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HAZEL Middle ALCINDIA Last LEMON

4. DATE OF DEATH: Month MARCH Day 20 Year 19 59

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 11/14/ 1900

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Confectionary

11. BIRTHPLACE (State or foreign country): TERRA ALTA,W.VA.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN ELSEY

14. MOTHER'S MAIDEN NAME: MAXIE FORMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 234-03-0635

17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ADENOCARCINOMA OF LEFT BREAST — INTERVAL BETWEEN ONSET AND DEATH: 16 mos
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11 - 21, 19 58, to 3-21, 19 59, that I last saw the deceased alive on 3 - 21, 19 59, and that death occurred at 9:20AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph W. Ballin, M.D. — ADDRESS (Street, city or town, state): 62 Greene St. — DATE SIGNED: 3-22-59

PHYSICIAN'S NAME (Type): Ralph W. Ballin, M.D. — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar. 23, 1959

22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Charles L. George, Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: MAR 26 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kuns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2542 — Reg. Dist. No. 02547

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA — b. COUNTY: MINERAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIDGELEY 85 X-3
d. STREET ADDRESS: RFD #1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First CHARLES — Middle J. — Last MACKERT
4. DATE OF DEATH: Month MARCH — Day 15 — Year 1959

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 5-16-1900
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Baker
10b. KIND OF BUSINESS OR INDUSTRY: Wholesale Bakery
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA McKeesport
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES J. MACKERT (Deceased)
14. MOTHER'S MAIDEN NAME: LUCY SCHELLHOUSE (Deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-05-6878
17. INFORMANT: CHART — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumococcus Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 11 days
490 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Lobar Pneumonia — One Month
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month — Day — Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-5-, 19 59 to 3-15-, 19 59, that I last saw the deceased alive on 3-14-, 19 59, and that death occurred at 9:17 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. T. Johnson Jr. M.D. — ADDRESS (Street, city or town, state): 16 Green St, Cumberland Md — DATE SIGNED: 3-16-59
PHYSICIAN'S NAME (Type): J. T. JOHNSON, M.D. — 16 Green Street Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-19-59
22c. NAME OF CEMETERY OR CREMATORY: St. Peter & Paul Cem
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: MAR 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

James F. Scarpelli

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2543 **CERTIFICATE OF DEATH** Reg. Dist. No. 02548

1. PLACE OF DEATH
a. COUNTY: ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 15 MINS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL WARWICK AND MEMORIAL AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 1 137 REYNOLDS STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BABY Middle GIRL Last MATHEWS

4. DATE OF DEATH: Month MARCH Day 15 Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 15, 1959

9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES D. MATHEWS

14. MOTHER'S MAIDEN NAME: RUTH LAVERNE GEORGE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hydrops — INTERVAL BETWEEN ONSET AND DEATH
770.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 15 March 1959 to ~, 19___, that I last saw the deceased alive on 15 March 1959, and that death occurred at 6:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Leland Ransom M.D.
ADDRESS (Street, city or town, state): 63 Greene St. Cumberland, Md.
DATE SIGNED

PHYSICIAN'S NAME (Type): Dr. Leland Ransom

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 3-17-59
22c. NAME OF CEMETERY OR CREMATORY: Memorial Hospital
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Memorial Hospital per L. Mathews
ADDRESS: Memorial Avenue Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: MAR 18 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kinnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2583

CERTIFICATE OF DEATH

02549
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Cumberland
c. LENGTH OF STAY IN 1b: 83 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Valley Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 1 Valley Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First AUGUSTINE Middle M. Last McELFISH

4. DATE OF DEATH: Month March Day 31, Year 1959 19

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 13, 1872
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Flintstone, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John McElfish
14. MOTHER'S MAIDEN NAME: Isabelle Duncan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Melissa McElfish Address: Valley Road Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Congestive Heart Failure — 1½ mos
DUE TO
(c): Arterio sclerotic Heart Disease — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Vascular Accident - ? Hemiplegia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. ____, 19 59, to Mar. 31, 19 59, that I last saw the deceased alive on Mar. 27, 19 59, and that death occurred at 11:00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William R James M.D. ADDRESS (Street, city or town, state): 441 N. Centre St. DATE SIGNED: 4-2-59
PHYSICIAN'S NAME (Type): William R James Cumberland, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/3/1959
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: APR 6 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG240 3-19-59 et

2544

CERTIFICATE OF DEATH

02550

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 204 Elder Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland 02
d. STREET ADDRESS: 226 Elder St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Milton — Last: Nealis

4. DATE OF DEATH: Month: March — Day: 13 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 24, 1867

9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired ~~Farmer~~ Labor

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Peoria, Ill

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Nealis

14. MOTHER'S MAIDEN NAME: Diana McBride

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Harry Nealis — Address: 204 Elder St Cumberland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 3 mo.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Heart Disease
DUE TO
(c) Abdominal Carcinomatosis — 2 mo.

157x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Advanced age

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY: Month, Day, Year: none — Hour: o. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 11, 1956, to March 13, 1959, that I last saw the deceased alive on March 13, 1959, and that death occurred at 5.10A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James P. Hallinan M.D. — M.D. — ADDRESS (Street, city or town, state): 140 Bedford Street — DATE SIGNED: 3/14/59

PHYSICIAN'S NAME (Type): James P. Hallinan M. D. — Cumberland, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-16-59
22c. NAME OF CEMETERY OR CREMATORY: Fort Ashby Cem.
22d. LOCATION (City, town, or county) (State): Fort Ashby, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: MAR 17 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2582 CERTIFICATE OF DEATH

Reg. Dist. No. 02551

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 84 E. Main St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg
d. STREET ADDRESS: 84 E. Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alvin; Middle: C.; Last: Nickel

4. DATE OF DEATH: Month: March; Day: 12th,; Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 12th, 1880

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self-employed Uph.

10b. KIND OF BUSINESS OR INDUSTRY: Upholsterer

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Conrad Nickel

14. MOTHER'S MAIDEN NAME: Margaret Hartman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Spanish-Amer.

16. SOCIAL SECURITY NO.

INFORMANT Address: Florian Nickel, 157 First St., F'bg. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
420.0
DUE TO (b): arteriosclerotic Heart Disease — 3 yrs
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1953 to March, 1959, that I last saw the deceased alive on March 17, 1959, and that death occurred at 4:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John B. Davis, M.D. — ADDRESS (Street, city or town, state): 2 Broadway, Frostburg, Md. — DATE SIGNED: 3/13/59

PHYSICIAN'S NAME (Type): John B. Davis, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 3-15-59
22c. NAME OF CEMETERY OR CREMATORY: Homewood Cemetery
22d. LOCATION (City, town, or county) (State): Pittsburgh, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Joseph R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: MAR 17 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2545

CERTIFICATE OF DEATH

02552
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 708 Frederick St.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland,
d. STREET ADDRESS: 708 Frederick St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cecil; Middle: James; Last: Northcraft

4. DATE OF DEATH: Month: March; Day: 26; Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 18, 1912

9. AGE (In years last birthday): 46 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager

10b. KIND OF BUSINESS OR INDUSTRY: Clothing Store

11. BIRTHPLACE (State or foreign country): Accident, Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Frank J. Northcraft

14. MOTHER'S MAIDEN NAME: Elizabeth Hoffman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-10-7425

17. INFORMANT: Mrs. Lillian J. Northcraft — Address: Cumberland, Md 708 Frederick St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hour
DUE TO
(b): Arteriosclerotic heart disease — 2 months
DUE TO
(c): —

420.0
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-3-, 1959, to 3-26, 1959, that I last saw the deceased alive on 3-20-, 1959, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Brings M.D. — ADDRESS (Street, city or town, state): 57 Greene St., — DATE SIGNED:

PHYSICIAN'S NAME (Type): Lewis Brings M.D. — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/29/59
22c. NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery
22d. LOCATION (City, town, or county) (State): Accident, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George — ADDRESS: Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 30 59

24b. REGISTRAR'S SIGNATURE: Arthur E. Krings

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG239 3-12-59 et

2546

CERTIFICATE OF DEATH

02553

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland,
d. STREET ADDRESS: 1 Cresap Drive-Bowling Green
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edith — Middle: E. — Last: Oats
4. DATE OF DEATH: Month: March — Day: 5 — Year: 59
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/9/1880
9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): W. VA.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: George H. Oates
14. MOTHER'S MAIDEN NAME: Mary Blacjburn
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Brother- Marshall Oats, Baltimore, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrum of the month (hemorrhage) — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b): melatostic cerebrum Speck — 1 year
DUE TO
(c):

144X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-3-, 1956, to 3-5, 1959, that I last saw the deceased alive on 3-5-, 1959, and that death occurred at 9:00P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L Binns, M.D. — ADDRESS (Street, city or town, state): 57 Queen St. Cumberland Md — DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/8/1959
22c. NAME OF CEMETERY OR CREMATORY: Hill Crest Cem.
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: MAR 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G240, 3/23/59 fcy

2547

CERTIFICATE OF DEATH

02554

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 20days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 521 HENDERSON AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: INA — Middle: K. — Last: PORTER

4. DATE OF DEATH: Month: MARCH — Day: 14 — Year: 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3-1-03

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurses Aide

10b. KIND OF BUSINESS OR INDUSTRY: Hospital

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Keesee

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218 24 8654

17. INFORMANT: Chart — Address: Harmon Porter Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO
581.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cirrhosis of the liver — 7 yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-1-, 1959, to 3-14, 1959, that I last saw the deceased alive on 3-14-59, 19, and that death occurred at 9:35A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L Brings M.D.
ADDRESS (Street, city or town, state): 57 GREEN STREET CUMBERLAND, Md.
DATE SIGNED:

PHYSICIAN'S NAME (Type): LEWIS BRINGS, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/17/1959
22c. NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight
ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: MAR 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2583

CERTIFICATE OF DEATH

02555

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 15 Yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 115 Hill Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg
d. STREET ADDRESS: 115 Hill Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: Elizabeth — Last: Pressman

4. DATE OF DEATH: Month: March — Day: 17th, — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 6th, 1930

9. AGE (In years last birthday): 29 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own housework

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Herbert Meyers

14. MOTHER'S MAIDEN NAME: Grace Rodda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT Address: Donald Pressman, 115 Hill St., F'bg., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Dilatation — Sudden
DUE TO (b): Influenza — 3 Days
DUE TO (c):

481 X

Conditions, if any, which gove rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 13, 1959, to Mar 17, 1959, that I last saw the deceased alive on Mar 16, 1959, and that death occurred at 2:15 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W O McLane M.D.

ADDRESS (Street, city or town, state): 167 E. Main St., Frostburg, Md.

DATE SIGNED

PHYSICIAN'S NAME (Type): W. O. McLane, M.D. " " " Mar 18 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-19-59

22c. NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery

22d. LOCATION (City, town, or county) (State): Eckhart, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Joseph R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: MAR 20 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2548

Reg. Dist. No. 02556

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 5yr.6mo.16das.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sylvan Retreat

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Cumberland
d. STREET ADDRESS: Homewood Addition
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Emma; Middle Brode; Last Rice
4. DATE OF DEATH: Month March; Day 30; Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 7, 1878
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Brode
14. MOTHER'S MAIDEN NAME: Rosena Lemmert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Sylvan Retreat Records, Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	420 Coronary Sclerosis	?
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	422 Myocardial Degeneration	?
DUE TO (c)	450 General arteriosclerosis	?

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 304 Senile psychosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 14, 1953 to Mar. 30, 1959, that I last saw the deceased alive on March 28 1959, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean M.D. ADDRESS (Street, city or town, state): 49 Greene St. DATE SIGNED

PHYSICIAN'S NAME (Type): James E. McLean, M.D. 49 Greene St., Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/1/1959
22c. NAME OF CEMETERY OR CREMATORY: Mt. Pleasant Cem.
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: APR 1 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2549 CERTIFICATE OF DEATH

Reg. Dist. No. 02557

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1 hour
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X La Vale
d. STREET ADDRESS: 441 National Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: TEXI Middle: Last: RITCHIE

4. DATE OF DEATH: Month: March Day: 5 Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 22, 1886
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Harman, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Cooper
14. MOTHER'S MAIDEN NAME: Elmira McDonald

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: John W. Ritchie, [illegible] Address: La Vale, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic heart disease — 6 months
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-4, 19 59, to 3-5, 19 59, that I last saw the deceased alive on 3-5, 19 59, and that death occurred at 10:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L Ritchie M.D. ADDRESS (Street, city or town, state): 57 Greene St. DATE SIGNED:
PHYSICIAN'S NAME (Type): Cumberland Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/8/1959
22c. NAME OF CEMETERY OR CREMATORY: Cooper Cemetery
22d. LOCATION (City, town, or county) (State): Harman, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: William M. Kight, ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: MAR 9 '59
24b. REGISTRAR'S SIGNATURE: Curtis L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

Item 18 Film 241 4-6-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2550 CERTIFICATE OF DEATH

Reg. Dist. No. 02558

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CUMBERLAND
d. STREET ADDRESS: RT. #3, BEDFORD ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LINDA Middle SUE Last ROYCE

4. DATE OF DEATH: Month MARCH Day 26 Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY 12
9. AGE (In years last birthday): 2 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): MARYLAND Patuxent River
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT L. ROYCE
14. MOTHER'S MAIDEN NAME: SHIRLEY A CAPOROSSI

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Neiman - Picks Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs. 8 mos.
289.0
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 1959, to March, 1959, that I last saw the deceased alive on March 26, 1959, and that death occurred at 7:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H. Overton Himmelwright M.D.
ADDRESS (Street, city or town, state): 133 Virginia Ave Cumberland, Md.
DATE SIGNED: 3/28/59
PHYSICIAN'S NAME (Type): DR. OVERTON HIMMELWRIGHT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-28-59
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli, Cumberland, Md.
24a. REGISTERED BY REGISTRAR DATE: MAR 30 59
24b. REGISTRAR'S SIGNATURE: Arthur S. Young

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2551

02559 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland,
d. STREET ADDRESS: 21 N. Lee St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARA — Middle REGINA — Last SCHREIBER

4. DATE OF DEATH: Month March — Day 18, — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 27, 1907

9. AGE (In years last birthday): 51 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Grocery Store

11. BIRTHPLACE (State or foreign country): Eckhart, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Condry

14. MOTHER'S MAIDEN NAME: Mollie Hershberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No,

16. SOCIAL SECURITY NO.: 578-40-6977

17. INFORMANT: Mr. Joseph F. Schreiber — Address: 21 N. Lee St., Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemothorax, Left — INTERVAL BETWEEN ONSET AND DEATH: 10 Min.

451X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Ruptured Dissecting Aneurysm — 10 Min.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: March 18, 1959

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/21/59

22c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul's

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George — ADDRESS: Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 20 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2552 CERTIFICATE OF DEATH

02560

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 65 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 515 E. FIRST STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELEANOR Middle Lost SHAW

4. DATE OF DEATH: Month MARCH Day 14 Year 19 59

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: FEBRUARY 14 1880

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND-KIFER

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LUKE ROBERTSON

14. MOTHER'S MAIDEN NAME: MATHILDA MIDDLETON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
DUE TO (b): Myocarditis & Decompensation — 5 yrs
DUE TO (c):

422.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 5, 19 59, to Mar 14, 19 59, that I last saw the deceased alive on Mar 14, 19 59, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Claye E Durrett M.D. ADDRESS (Street, city or town, state): 236 Va Ave Cumberland DATE SIGNED: 3/15/59

PHYSICIAN'S NAME (Type): CLAYE E. DURRETT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-17-1959

22c. NAME OF CEMETERY OR CREMATORY: Mt. Herman Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli, Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: MAR 17 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02561

Reg. Dist. No.

2564

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × Lonaconing
d. STREET ADDRESS: West Main
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William; Middle: ; Last: Shook

4. DATE OF DEATH: Month: March; Day: 27; Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 23, 1884

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Morefield, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Shook

14. MOTHER'S MAIDEN NAME: Virginia See

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. William Shook "Wife" — Address: Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Ischemia — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b): Arteriosclerosis - CVA — years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Glaucoma, Chronic gastritis, Tertiary Lues

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 19 59, to March 27 19 59, that I last saw the deceased alive on March 26, 19 59, and that death occurred at 5 a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Leslie R. Miles Jr M.D. — ADDRESS (Street, city or town, state): LONACONING MD — DATE SIGNED: 3.28.59

PHYSICIAN'S NAME (Type): LESLIE R. MILES JR

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3/29/59	Memorial Park	Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	DATE APR 1 '59	Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02562
Reg. Dist. No.

2553

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland, Md.
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital--D.O.A.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Friendsville, Md. IIX-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EUGENE — Middle EDWARD — Last SINES
4. DATE OF DEATH: Month March — Day 9 — Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 28, 1918
9. AGE (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sawmill operator
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Friendsville, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Christ Sines
14. MOTHER'S MAIDEN NAME: Orpha Morefield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 172-16-5100
17. INFORMANT: Mrs. Jessie Sines, Friendsville, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Hemopneumothorax	30Min.
DUE TO (b)	Fracture of 4th-5th ribs, right	30 Min.
DUE TO (c)		

835X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Tractor upset pinning victim.
20c. TIME OF INJURY — Hour: 3:15 p. m. — Month, Day, Year: Mar. 9 1959
20d. INJURY OCCURRED While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm
20f. (City or town) (County) (State): Near Corriganville, Alleg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: March 9, 1959
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/12/59
22c. NAME OF CEMETERY OR CREMATORY: Blooming Rose
22d. LOCATION (City, town, or county) (State): Friendsville, Garrett Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Don J. Neuman
ADDRESS: Grantsville, Md.
24a. REC'D BY REGISTRAR DATE: MAR 12 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2554 — Reg. Dist. No. 02563

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4 HRS. 32 MIN.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 1 209 BEDFORD STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BABY — Middle: GIRL — Last: SMITH

4. DATE OF DEATH: Month: MARCH — Day: 3 — Year: 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 3, 1959

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 4 — Min. 32

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: RICHARD E. SMITH

14. MOTHER'S MAIDEN NAME: BARBARA A. CLAIRE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT (Address): WARWICK & MEMORIAL AVENUE
MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Anomalies — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
759.3
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3 March 59 to 4 March 59, that I last saw the deceased alive on 3 March 59, and that death occurred at 1:24 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Ransom M.D. — ADDRESS (Street, city or town, state): 63 Greene St Cumberland — DATE SIGNED

PHYSICIAN'S NAME (Type): DR. L. RANSOM M. D. 63 Greene St. Cumberland, Md. — 4 March 59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 4, 1959
22c. NAME OF CEMETERY OR CREMATORY: XXXXXX Lewis Cemetery
22d. LOCATION (City, town, or county) (State): Near Oldtown, Md. Alleg. Co.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 6 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

2060192XV4

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02564

2555

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — Cumberland — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland, Md.

c. LENGTH OF STAY IN 1b: 7 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland, Md.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

d. STREET ADDRESS: 288 Cresap Drive, Bowling Green

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: Dillon — Last: Smith

4. DATE OF DEATH: Month: March — Day: 27th — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-1-1885

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Various

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Addison Smith

14. MOTHER'S MAIDEN NAME: ~~Parrell~~ Margaret Parrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

INFORMANT — Address: Pt's Chart, Sacred Heart Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): generalized arteriosclerosis — 2 yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-1-, 1957, to 3-27-, 1959, that I last saw the deceased alive on 3-27-, 1959, and that death occurred at 830 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L Brings M.D. — ADDRESS (Street, city or town, state): 57 Green Street, Cumberland, Md. — DATE SIGNED: 3-30-59

PHYSICIAN'S NAME (Type): Dr. Lewis Brings, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/30/1959

22c. NAME OF CEMETERY OR CREMATORY: Potter Cemetery

22d. LOCATION (City, town, or county) (State): Eckhart, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: MAR 31 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2590

Reg. Dist. No. 02565

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellerslie
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Ellerslie
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Middle Last: Annie M. Snowden

4. DATE OF DEATH: Month Day Year: March 5, 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December 4, 1872

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Bedford Co., Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nathaniel Smith

14. MOTHER'S MAIDEN NAME: Elizabeth Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Mrs. Roy Clites, Ellerslie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Valvular Heart Disease, Chronic — INTERVAL BETWEEN ONSET AND DEATH: Approx 15 yrs.
421.4
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 27, 19 58, to March 5, 19 59, that I last saw the deceased alive on March 4, 19 59, and that death occurred at R M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John A Topper M.D. — ADDRESS (Street, city or town, state): Hyndman, Penna. — DATE SIGNED: March 6, 1959

PHYSICIAN'S NAME (Type): John A. Topper, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 7, 1959

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Harvey L. Beegle, Hyndman, Pa.

24a. REC'D BY REGISTRAR DATE: MAR 10 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2556

CERTIFICATE OF DEATH

02566

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 8 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 421 North Waverly Terrace

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 421 N. Waverly Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle ETTA Last SPEROW

4. DATE OF DEATH: Month March Day 13 Year 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 6, 1888

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Oldtown, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Crabtree

14. MOTHER'S MAIDEN NAME: Emma Zimmerly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Chas. C. Sperow — Address: 421 N. Waverly Terrace, Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mitral stenosis Coronary thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 4 or 5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1955 to 3-13, 19 59, that I last saw the deceased alive on 3-10 19 59, and that death occurred at 12:55 M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James T. Johnson Jr. M.D.
ADDRESS (Street, city or town, state): 16 Greene St. Cumberland, Md.
DATE SIGNED: 3/14/59

PHYSICIAN'S NAME (Type): James T. Johnson, Jr. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/16/59
22c. NAME OF CEMETERY OR CREMATORY: Davis Mem.Meth. Cem
22d. LOCATION (City, town, or county) (State): Allegany County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2557 **CERTIFICATE OF DEATH** 02567

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

c. LENGTH OF STAY IN 1b: 45 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 14 Willison Place

d. STREET ADDRESS: 14 Willison Place

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John Middle Henry Lost Stevenson

4. DATE OF DEATH: Month March Day 25 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 9, 1893

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Operator

10b. KIND OF BUSINESS OR INDUSTRY: Gasoline

11. BIRTHPLACE (State or foreign country): Midland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Stevenson

14. MOTHER'S MAIDEN NAME: Martha Clites

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-10-6807

17. INFORMANT Address: Mrs. Etta Wilson, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial Asthma — INTERVAL BETWEEN ONSET AND DEATH: 5 years
DUE TO
212 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cyst of Lung — 10 years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 49 March 24 19 59 to 19 that I last saw the deceased alive on March 24 19 59, and that death occurred at 7:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E Broadrup M.D.

ADDRESS (Street, city or town, state): 202 Virginia Ave.

DATE SIGNED

PHYSICIAN'S NAME (Type): Dr. E. E. Broadrup — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-28-59

22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli, Cumberland, Md.

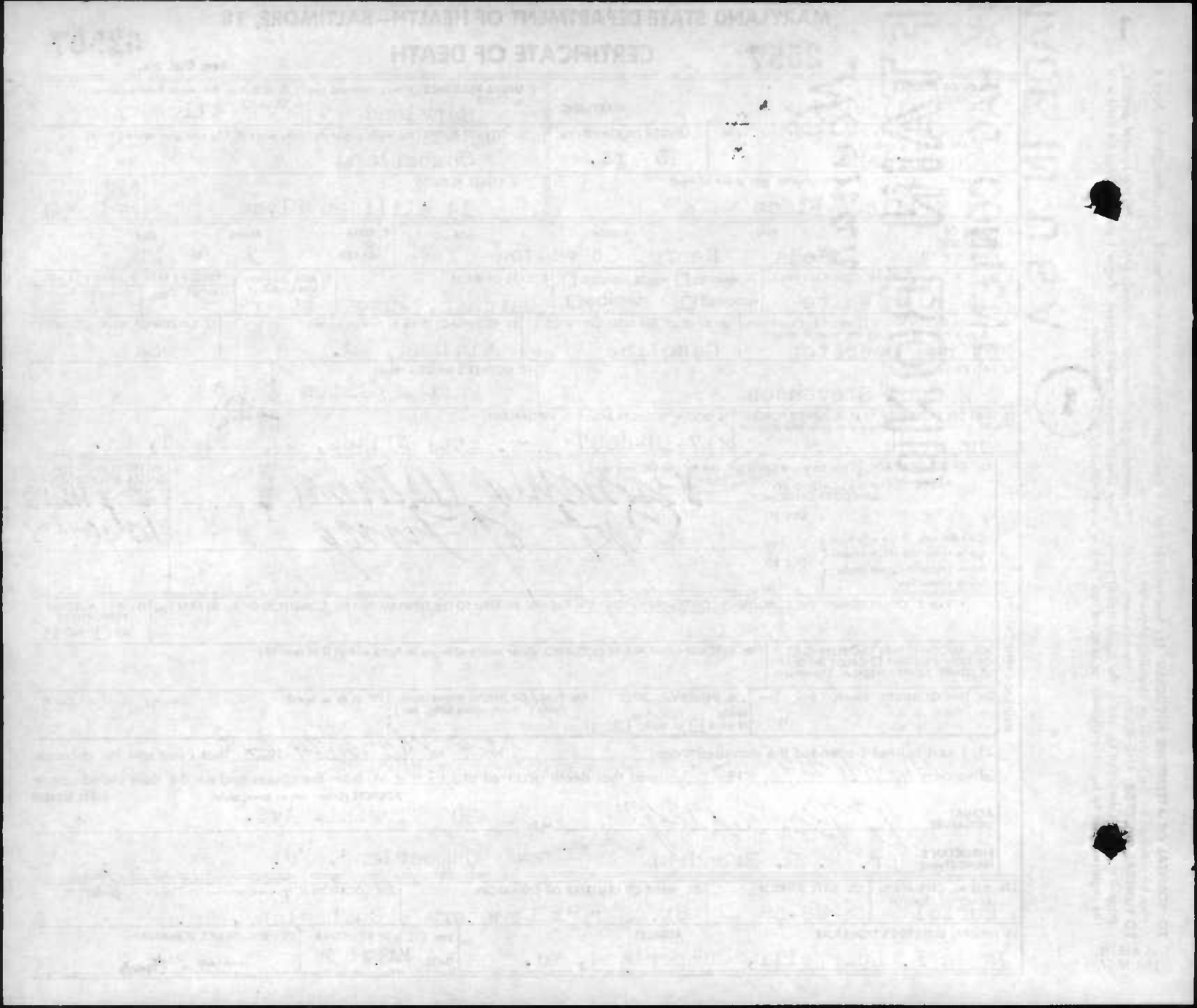
24a. REC'D BY REGISTRAR DATE: MAR 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2591

CERTIFICATE OF DEATH

02568 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellerslie
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Ellerslie
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Richard Middle E. Last Stuby

4. DATE OF DEATH: Month March Day 29 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 5, 1897

9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brakeman

10b. KIND OF BUSINESS OR INDUSTRY: B&O Railroad

11. BIRTHPLACE (State or foreign country): Fossilville, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Stuby

14. MOTHER'S MAIDEN NAME: Amanda Wolford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-9942

17. INFORMANT: Mrs. Phoebe Stuby, Ellerslie, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Myocardial Infarction — 1 5 mos
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-12, 1952, to 3-29, 1959, that I last saw the deceased alive on 3-24, 1959, and that death occurred at 6:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: William P. James M.D. ADDRESS (Street, city or town, state): 441 N. Centre St., DATE SIGNED: 3-30-59

PHYSICIAN'S NAME (Type): WILLIAM P. JAMES, M. D, CUMBERLAND, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 31, 1959

22c. NAME OF CEMETERY OR CREMATORY: Lybarger Cemetery

22d. LOCATION (City, town, or county) (State): Buffalo Mills, Pa. RD#1

23. FUNERAL DIRECTOR'S SIGNATURE: Harvey N. Zeigler ADDRESS: Hyndman, Pa.

24a. REC'D BY REGISTRAR DATE: APR 1 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Howe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2558 — Reg. Dist. No. 12569

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland Md

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 814 Sylvan Ave.

d. STREET ADDRESS: 814 Sylvan Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna Middle: Belle Last: Stump

4. DATE OF DEATH: Month: March Day: 13 Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1-24-1878

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Sylvanus Robey

14. MOTHER'S MAIDEN NAME: Mary Doyle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Watkins Address: 814 Sylvan Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Myocarditis with Decompensation 3 Weeks

DUE TO

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-2-59, 19__, to 3-13, 19 59, that I last saw the deceased alive on 3-12 19 59, and that death occurred at 5 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James T. Johnson M.D. ADDRESS (Street, city or town, state): 16 Green St. DATE SIGNED: 3-13-59

PHYSICIAN'S NAME (Type): James T. Johnson Jr. M.D. Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/15/59

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cem.

22d. LOCATION (City, town, or county) (State): Cumberland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James Shea Inc. ADDRESS: Cumb. Md

24a. REC'D BY REGISTRAR DATE: MAR 16 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kress

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

1

FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-[illegible] Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02570

2592

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dawson
c. LENGTH OF STAY IN 1b: 6 Wks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Mi. N. McCoole

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Dawson-Rural
d. STREET ADDRESS: 3 Mi. N. McCoole
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Cathy — Middle: J. — Last: TAYLOR

4. DATE OF DEATH: Month: March — Day: 4 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 30, 1958

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 2 Days: 4
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Roy F. Taylor

14. MOTHER'S MAIDEN NAME: Sandra K. Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Roy Taylor- R.D. 3, Keyser, W.Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Asphysiation — INTERVAL BETWEEN ONSET AND DEATH: 10-15 Min.

500X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Aspiration of Stomach contents

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute Tracheo-bronchitis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D. — March 4, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/5/59

22c. NAME OF CEMETERY OR CREMATORY: Maysville

22d. LOCATION (City, town, or county) (State): Maysville W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE: E. J. Boal

ADDRESS: Westernport, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 6 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

2047151XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2559 — Reg. Dist. No. 02571

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA VALE, MARYLAND
d. STREET ADDRESS: 15 NORTH LAVALE STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RUTH — Middle E. — Last TAYLOR

4. DATE OF DEATH: Month MARCH — Day 29 — Year 19 59

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 2, 1903

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House keeper at home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM MCFARLAND

14. MOTHER'S MAIDEN NAME: MAUDE MICKEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: MEMORIAL HOSPITAL CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Ca Pulmonale — INTERVAL BETWEEN ONSET AND DEATH: 2 mos

171X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Pulmonary Fibrosis and Metastatic Ca. — 1 yr

DUE TO (c): Carcinoma of Cervix — 7 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:15 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 122 S. Centre St. Cumberland Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): MOULD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/1/59

22c. NAME OF CEMETERY OR CREMATORY: Rest Lawn Cemetery

22d. LOCATION (City, town, or county) (State): LaVale Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ruth E. Silcox Cumberland Maryland

24a. REC'D BY REGISTRAR — DATE: APR 3 '59

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02572

Reg. Dist. No. 2560

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMT. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 3/23/59
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 909 Fayette Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GWILYM — Middle GOUGH — Last THOMAS

4. DATE OF DEATH: Month March — Day 24 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 22, 1900

9. AGE (In years last birthday): 58 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Certified Public Acc.

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (State or foreign country): Canaskee, Wales

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Thomas

14. MOTHER'S MAIDEN NAME: Laura Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 209-09-0737

17. INFORMANT: Mrs. Camille S. Thomas — Address 909 Fayette Street Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Hepatic Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

581.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hepatic Cirrhosis — -----

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: March 24, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/26/59

22c. NAME OF CEMETERY OR CREMATORY: St. Peter & Paul Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 26 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

1

FOR STATE HEALTH DEPT.

Item 18 Film 240 4-3-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02573

2593 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, nr. Oldtown, Md.
c. LENGTH OF STAY IN 1b: 3 mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RT. 4 , Box 264, Cumberland, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural, nr. Oldtown, Md.
d. STREET ADDRESS: Rt. 4, Box 264, Cumberland, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS — Middle Eugene — Last WARD

4. DATE OF DEATH: Month March — Day 23 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 20, 1958

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months 3mos, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Daniel F. Ward

14. MOTHER'S MAIDEN NAME: Rhoda Ritchie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Daniel F. Ward Cumberland, Maryland — Address: Rt. 4, Box 264

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ASPHYXIATION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

571.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): ASPIRATION OF STOMACH CONTENTS — 11

DUE TO (c): Gastro-enteritis, Non Specific — 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, o. m. p. m., Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

DATE SIGNED: March 23, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/25/59

22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 26 '59

24b. REGISTRAR'S SIGNATURE: Arthur E. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

2060284XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2561 — 02574 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 4 GRAND AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELIZABETH — Middle: V. — Last: WELCH

4. DATE OF DEATH: Month: MARCH — Day: 8, — Year: 19 59.

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPTEMBER 1,

9. AGE (In years last birthday): 42 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Variety Store

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: RUSSELL STEWART

14. MOTHER'S MAIDEN NAME: BESSIE P. MILLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-7947

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Meningitis - Influenza — INTERVAL BETWEEN ONSET AND DEATH: 3 days
340.0
DUE TO
Conditions, if any, which gove rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar. 5, 1959 to Mar 8, 1959 that I last saw the deceased alive on Mar. 8, 1959, and that death occurred at 2:42 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Clay E. Durrett M.D. — ADDRESS (Street, city or town, state): 236 W. 4th St Cumberland Md — DATE SIGNED: 3/8/59

PHYSICIAN'S NAME (Type): DR. CLAY E. DURRETT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Mar.11,1959 — 22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Pk. — 22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli, Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: MAR 13 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02575

2562

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND

c. LENGTH OF STAY IN 1b: 10 DAYS

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: PENNSYLVANIA
b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCKWOOD 75X-3

d. STREET ADDRESS: Rockwood RD #3

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALBERT Middle J Last WEYAND

4. DATE OF DEATH: Month MARCH Day 3 Year 19 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: NOVEMBER 17

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALBERT WEYAND

14. MOTHER'S MAIDEN NAME: ELIZABETH HOWARD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 175-16-9472A

17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardio. Vascular Lesion — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
DUE TO
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Benign Prostatic Hypertrophy with retention

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 21 Feb, 19 59, to 3 Mar, 19 59, that I last saw the deceased alive on 3 Mar, 19 59, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James G Stegmaier M.D. — ADDRESS (Street, city or town, state): 122 So Center St, Cumberland Md — DATE SIGNED: 4 Mar 59

PHYSICIAN'S NAME (Type): JAMES G. STEGMAIER

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: March 6, 1959

22c. NAME OF CEMETERY OR CREMATORY: Hedgy Chapel cemetery

22d. LOCATION (City, town, or county) (State): Rockwood RD#3 Somerset Co Pa

23. FUNERAL DIRECTOR'S SIGNATURE: William J Hood — ADDRESS: Rockwood Pa

24a. REC'D BY REGISTRAR DATE: MAR 11 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2563 (Reg. Dist. No.) 02576

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 23 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA — b. COUNTY: MINERAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIDGELEY 85X-3
d. STREET ADDRESS: 117 MAIN STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GERTRUDE — Middle MAE — Last WHEELER
4. DATE OF DEATH: Month MARCH — Day 26 — Year 1959
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DECEMBER 23, 1881
9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): OHIO, GREENBRIER, CO.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: URIAH SAVILLE
14. MOTHER'S MAIDEN NAME: ROSE WEIGLE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Adeno carcinoma of colon — INTERVAL BETWEEN ONSET AND DEATH: 20 years!
153.8
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-30, 1959, to 3-26, 1959, that I last saw the deceased alive on 3-26, 1959, and that death occurred at 11:10 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph W. Ballin, M.D. — ADDRESS (Street, city or town, state): 62 Greene St. — DATE SIGNED: 2-28-59

PHYSICIAN'S NAME (Type): DR. RALPH BALLIN — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 29, 1959
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: CHARLES L. GEORGE, CUMBERLAND, MD.
24a. REC'D BY REGISTRAR DATE: MAR 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02577

2564

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 21 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 182 Thomas Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS WARD — Middle — Last WHITE
4. DATE OF DEATH: Month March — Day 8 — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 10, 1937
9. AGE (In years last birthday): 21 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: High School
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Carl R. White
14. MOTHER'S MAIDEN NAME: Laura N. Troxell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT — Address: Mr. Carl R. White, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 Hr.
420.1
DUE TO (b): Coronary Atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: March 18 1959
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-11-1959
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli, Cumberland, Md.
24a. REC'D BY REGISTRAR — DATE: MAR 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
8M 2/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02578
Reg. Dist. No.

2565

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 108 W.Third St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANCES — Middle Emily — Last WICKARD
4. DATE OF DEATH: Month March — Day 3 — Year 1959
5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 7, 1903
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dishwasher
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (State or foreign country): Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Samuel T. Mears
14. MOTHER'S MAIDEN NAME: Martha E. Reese
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-24-7378
17. INFORMANT: Sylvester W. Wickard — Address: 108 W. 3rd St., Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 15 days
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertension and Sclerosis — ---
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES Yes NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour — Month, Day, Year — a. m. / p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: March 3, 1959
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/5/59
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR — DATE: MAR 6 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02579

2566 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
o. COUNTY: Allegany — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE: Maryland b. COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

c. LENGTH OF STAY IN 1b: 4 yrs. 10mos.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cresaptown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sylvan Retreat

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles Middle William Last Wigfield

4. DATE OF DEATH: Month March Day 3 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/30/80

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stone Quarry - Miner

10b. KIND OF BUSINESS OR INDUSTRY: Industrial

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elijah Wigfield

14. MOTHER'S MAIDEN NAME: Elizabeth Watson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Sylvan Retreat Cumb Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o): 420 Coronary Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: ?

420.1

DUE TO (b): 450 General arteriosclerosis — ?

Conditions, if ony, which gave rise to immediate couse (o), stating the underlying cause last.

DUE TO (c): 592 Chronic Nephritis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 304 Senile psychosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 3 1954, to Mar. 3 1959 that I last saw the deceased alive on Feb 28th 1959, and that death occurred at 6 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean M.D. ADDRESS (Street, city or town, State): 49 Greene St Cumberland DATE SIGNED: 3/3/59

PHYSICIAN'S NAME (Type): James E. McLean, M.D. 49 Greene St., Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar. 5. 1959

22c. NAME OF CEMETERY OR CREMATORY: Allegany Co. Cemetery

22d. LOCATION (City, town, or county): Cumberland (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein, Inc. ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: MAR 9 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2567 — Reg. Dist. No. — 02580

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 24 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mt. Savage
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

62

3. NAME OF DECEASED (Type or print): First: Anna — Middle — Last: Wilfong
4. DATE OF DEATH: Month: March — Day: 26 — Year: 19 59
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9/9/96
9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): W.Va.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: George Martin
14. MOTHER'S MAIDEN NAME: Anna Albright
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Chart

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: unk.
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): C V Disease — unk.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Recent operations @ Bunions + hammertoe @ Umbilical hernia + adhesions
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 Mar, 19 59, to 26 Mar, 19 59, that I last saw the deceased alive on 26 Mar, 1959, and that death occurred at 1¢ P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Carlton Brinsfield M.D. — ADDRESS (Street, city or town, state): 232 Baltimore Ave Cumberland, Md — DATE SIGNED: 3/27/59

PHYSICIAN'S NAME (Type): Dr. C. Brinsfield — 232 Baltimore Ave.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/28/59
22c. NAME OF CEMETERY OR ~~CREMATORY~~: ROSE HILL
22d. LOCATION (City, town, or county): THOMAS (State): W. VA.

23. FUNERAL DIRECTOR'S SIGNATURE: J. A. Duncan — ADDRESS: THOMAS, W. VA.
24a. REC'D BY REGISTRAR: MAR 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur E. Hauck

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1 M

2568

CERTIFICATE OF DEATH

02581

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland — c. LENGTH OF STAY IN 1b: 39 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 00 1018 Shades Lane	d. STREET ADDRESS: 1 1018 Shades Lane — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Robert	Middle: Charles	Last: Williams	4. DATE OF DEATH Month: March Day: 11 Year: 1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	June 3,1919	39 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Auto repair	Streets Body shop	Maryland	U.S.A.

13. FATHER'S NAME: John W. Williams	14. MOTHER'S MAIDEN NAME: Elizabeth Clites Gray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	W.W. II	217-10-7845	Mrs. Robert Williams	Cumberland,Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) *Acute Myelogenous Leukemia* — INTERVAL BETWEEN ONSET AND DEATH: *3 months*

204.3

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ________, 19*50*, to *25 Feb*, 19*59*, that I last saw the deceased alive on *25 Feb*, 19*59*, and that death occurred at *11:00 P*M, from the causes and on the date stated above.

Please see margin to left

ACTUAL SIGNATURE: *S. Weisman* M.D. — ADDRESS (Street, city or town, state): *59 Greene St* — DATE SIGNED: *3/13/59*

PHYSICIAN'S NAME (Type): *S. G. WEISMAN MD* — *Cumberland, Maryland*

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3/14/59	Zion Memorial Park	Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Ruth E. Silcox	Cumberland Maryland	DATE MAR 17 '59	[illegible signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Patient was under care of Dr. Loo Lay, Braddock Road, Cumberland and did this final illness. I saw patient only in consultation 2/25/59. Dr. Lay is to fill out this form. S. Weisman MD

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2585

Reg. Dist. No. 12589

1. PLACE OF DEATH
a. COUNTY Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport
c. LENGTH OF STAY IN 1b: 62 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 109 McKinley

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md
b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport
d. STREET ADDRESS: Westernport-R.D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Violet Middle Virginia Last Wilt

4. DATE OF DEATH: Month Mar. Day 24 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 22, 1896
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph E. Youst
14. MOTHER'S MAIDEN NAME: Mary E. Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Mrs. Geraldine E. Youst-Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 Days

331 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Arterio-sclerosis — 5 Years

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 18, 1959, to Mar. 24, 1959, that I last saw the deceased alive on Mar. 23, 1959, and that death occurred at 3:35 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul R Wilson M.D.
ADDRESS (Street, city or town, state): 111 Ashfield St. Piedmont, W.Va.
DATE SIGNED: 3-24-59
PHYSICIAN'S NAME (Type): Paul R. Wilson M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/27, 1959
22c. NAME OF CEMETERY OR CREMATORY: Philos
22d. LOCATION (City, town, or county) (State): Westernport Md.

23. FUNERAL DIRECTOR'S SIGNATURE: E. L. Beal
ADDRESS: Westernport, Md.
24a. REC'D BY REGISTRAR DATE MAR 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2569

CERTIFICATE OF DEATH

02583

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY: ALLEGANY	MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND	c. LENGTH OF STAY IN 1b: 4 HRS. 34 MINS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND	b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND	
d. STREET ADDRESS: 1 932 MARYLAND AVENUE	e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

	First	Middle	Last	4. DATE OF DEATH: Month	Day	Year
3. NAME OF DECEASED (Type or print)	BABY	GIRL	WOLFE	MARCH	10,	19 59

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE		MARCH 10, 1959				2	34

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		CUMBERLAND, MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
CHARLES E WOLFE	CAROLE J SCHOENADEL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		MEMORIAL HOSPITAL	CUMBERLAND MARYLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Prematurity 4-5 months Feb. — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs 34 mins.

776 X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/10, 19 59, to 3/10, 19 59, that I last saw the deceased alive on 3/10, 19 59, and that death occurred at 2:06P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: B. M. Schindler M.D. — ADDRESS (Street, city or town, state): 43 Bruce St Cumberland Md — DATE SIGNED: 3-11-59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3/11/59	Pleasant Grove Cem.	Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
H. Lee Silcox Cumberland, Md.	MAR 13 '59	Arthur E. Krause

2060 18/XVO